

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6159
State File No. 1689

BIRTH NO. 93614. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 4611 Greer	
3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) FLANIGAN c. (Last) N			4. DATE OF DEATH (Month) (Day) (Year) 2-21-49
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 2 - 1876
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? Mo	
13a. FATHER'S NAME RICHARD FLANIGAN		13b. MOTHER'S MAIDEN NAME CATHERINE BRENNAN	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME JOSEPH LANIGAN	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Potts disease</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>16</u> <u>491X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-13</u> , 19 <u>49</u> to <u>2-21</u> , 19 <u>49</u> that I last saw the deceased alive on _____, 19____, and that death occurred at <u>W.P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>J. P. Moore</u>		23b. ADDRESS M.D. 1515 Lafayette Ave.	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 2/23/49		24c. NAME OF CEMETERY OR CREMATORY CALVARY	
24d. LOCATION (City, town, or county) (State) St. Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Sasser</u>	
25. FUNERAL DIRECTOR'S ADDRESS 5700 NAT'L BRIDGE		DATE REC'D BY LOCAL REG. OFF. FEB 23 1949	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6897

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Ben Eloffman

Signed.....

Student Embalmer

Licensed Embalmer No. *4364*

P. O. Address *St. Louis Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.